

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-019366

STATE FILE NUMBER

Registration District No. **59**

Primary Registration District No. _____

Registrar's No. **86**

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 **0190**

2 **0190**

3

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

FILED JUN 11 1963

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cass	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dolan Twp		Length of stay in lb Instant	c. CITY OR TOWN Drexel Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4 Miles SW Freeman		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rt. 1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CLIFFORD Middle A. Last HALL		4. DATE OF DEATH Month 2 Day June Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1904
9. AGE (last birthday) 58		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) State of Texas
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Henry W. Hall	
13b. MOTHER'S MAIDEN NAME Nora May Anderson		14. NAME OF HUSBAND OR WIFE Lucille M. Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Address Archie Hall, Drexel, Missouri		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Trauma DUE TO (b) Brain injury DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Auto Accident	
20c. TIME OF INJURY 5:00 p.m. 6-2-63		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Country road 4 miles SW Freeman	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION Freeman	COUNTY Cass STATE MO
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Wm Cummings (Degree or title) Cass Co Coroner		22b. ADDRESS Hamersville MO	22c. DATE SIGNED 6-2-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5 June 1963	23c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery	23d. LOCATION (City, town, or county) Palisades, Colorado
24. FUNERAL DIRECTOR Atkinson Dickey Harrisonville, Mo.		25. DATE RECD. BY LOCAL REG. 6-5-63	26. REGISTRAR'S SIGNATURE Ray J. Suber

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

AUG 8 1963

RECEIVED

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert W. Peterson

Licensed Embalmer No. 7902
Hammond, Mo
P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.